FOR BHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0041392

Facility Name: Heritage Manor-Minonk

Address: 201 Locust Street (Number) Minonk (City) 61760 (Zip Code)

County: McLean

Telephone Number: (309) 432-2557 **Fax #** ( )

HFS ID Number: 370909086019

Date of Initial License for Current Owners: 1995

Type of Ownership:

	VOLUNTARY,NON-PROFIT	xx	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		xx	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Craig Ater **Telephone Number:** (309)823-7135

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Craig L. Ater

(Title) Senior V.P. & CFO

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

(Telephone) ( ) Fax # ( )

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	49	Skilled (SNF)	49	17,885	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5	23	Sheltered Care (SC)	23	8,395	5
6		ICF/DD 16 or Less			6
7	72	TOTALS	72	26,280	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	8,116	4,645	3,234	15,995	8
9	SNF/PED			0		9
10	ICF					10
11	ICF/DD					11
12	SC	1,177	4,606	0	5,783	12
13	DD 16 OR LESS					13
14	TOTALS	9,293	9,251	3,234	21,778	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 82.87%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [xx]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [xx]

I. On what date did you start providing long term care at this location?
Date started 1995

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [xx]

K. Was the facility certified for Medicare during the reporting year?
YES [xx] NO [ ] If YES, enter number of beds certified _____ and days of care provided 3,234

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [xx] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: _____ Fiscal Year: _____

* All facilities other than governmental must report on the accrual basis.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Minonk # 0041392 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	148,650	14,386		163,036		163,036	3,178	166,214			1
2	Food Purchase		91,967		91,967		91,967		91,967			2
3	Housekeeping	69,406	11,364		80,770		80,770	3	80,773			3
4	Laundry	55,132	8,745		63,877		63,877		63,877			4
5	Heat and Other Utilities			93,635	93,635		93,635	1,003	94,638			5
6	Maintenance	40,183	23,193	17,004	80,380		80,380	8,406	88,786			6
7	Other (specify):*											7
8	**TOTAL General Services**	313,371	149,655	110,639	573,665		573,665	12,590	586,255			8
	B. Health Care and Programs											
9	Medical Director			750	750		750		750			9
10	Nursing and Medical Records	722,406	45,691	3,789	771,886		771,886		771,886			10
10a	Therapy		229,254	218,310	447,564	(282,849)	164,715	39,947	204,662			10a
11	Activities	34,559	2,287		36,846		36,846		36,846			11
12	Social Services	18,823		2,228	21,051		21,051		21,051			12
13	CNA Training	2,466	125		2,591		2,591	1,130	3,721			13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	778,254	277,357	225,077	1,280,688	(282,849)	997,839	41,077	1,038,916			16
	C. General Administration											
17	Administrative	62,320			62,320		62,320	48,724	111,044			17
18	Directors Fees							3,617	3,617			18
19	Professional Services			180,496	180,496		180,496	(170,446)	10,050			19
20	Dues, Fees, Subscriptions & Promotions			49,837	49,837	(26,828)	23,009	(8,009)	15,000			20
21	Clerical & General Office Expenses	66,994	5,650	15,566	88,210		88,210	100,572	188,782			21
22	Employee Benefits & Payroll Taxes			267,334	267,334		267,334	26,176	293,510			22
23	Inservice Training & Education			1,134	1,134		1,134	848	1,982			23
24	Travel and Seminar			11,800	11,800		11,800	(9,801)	1,999			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			44,534	44,534		44,534	1,283	45,817			26
27	Other (specify):*			15,885	15,885		15,885	(15,000)	885			27
28	**TOTAL General Administration**	129,314	5,650	586,586	721,550	(26,828)	694,722	(22,036)	672,686			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,220,939	432,662	922,302	2,575,903	(309,677)	2,266,226	31,631	2,297,857			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Heritage Manor-Minonk #0041392 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			62,328	62,328		62,328	8,529	70,857			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			67,566	67,566		67,566	14,821	82,387			32
33	Real Estate Taxes			26,483	26,483		26,483		26,483			33
34	Rent-Facility & Grounds							4,405	4,405			34
35	Rent-Equipment & Vehicles			1,482	1,482		1,482	1,105	2,587			35
36	Other (specify):*											36
37	**TOTAL Ownership**			157,859	157,859		157,859	28,860	186,719			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					282,849	282,849		282,849			39
40	Barber and Beauty Shops		11		11		11		11			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					26,828	26,828		26,828			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**		11		11	309,677	309,688		309,688			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	1,220,939	432,673	1,080,161	2,733,773		2,733,773	60,491	2,794,264			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms		35		5
6	Rented Facility Space		34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(28)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(346)	20		17
18	Fines and Penalties				18
19	Entertainment	(16,505)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,520)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(15,000)	27		24
25	Fund Raising, Advertising and Promotional	(10,722)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule		23		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (44,121)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	104,612		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 104,612		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 60,491		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Heritage Manor-Minonk

ID# 0041392

Report Period Beginning: 01/01/05

Ending: 12/31/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5		0	35	5
6		0	34	6
7				7
8				8
9		0	30	9
10			32	10
11				11
12				12
13		0	2	13
14			32	14
15		0	33	15
16			24	16
17		(346)	20	17
18				18
19			24	19
20		0	27	20
21				21
22		(1,520)	19	22
23				23
24		(15,000)	27	24
25		(10,722)	20	25
26				26
27				27
28				28
29		0	23	29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(27,588)		49

STATE OF ILLINOIS — Summary A

Facility Name & ID Number Heritage Manor-Minonk **#** 0041392 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	3,178	0	0	0	0	0	0	0	0	3,178	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	3	0	0	0	0	0	0	0	0	3	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	1,003	0	0	0	0	0	0	0	0	1,003	5
6	Maintenance	0	0	8,406	0	0	0	0	0	0	0	0	8,406	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	12,590	0	0	0	0	0	0	0	0	12,590	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	39,947	0	0	0	0	0	0	0	0	0	39,947	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	1,130	0	0	0	0	0	0	0	0	1,130	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	39,947	1,130	0	0	0	0	0	0	0	0	41,077	16
	C. General Administration													
17	Administrative	0	0	48,724	0	0	0	0	0	0	0	0	48,724	17
18	Directors Fees	0	0	3,617	0	0	0	0	0	0	0	0	3,617	18
19	Professional Services	(1,520)	(178,976)	10,050	0	0	0	0	0	0	0	0	(170,446)	19
20	Fees, Subscriptions & Promotions	(11,068)	0	3,059	0	0	0	0	0	0	0	0	(8,009)	20
21	Clerical & General Office Expenses	0	0	100,572	0	0	0	0	0	0	0	0	100,572	21
22	Employee Benefits & Payroll Taxes	0	0	26,176	0	0	0	0	0	0	0	0	26,176	22
23	Inservice Training & Education	0	0	848	0	0	0	0	0	0	0	0	848	23
24	Travel and Seminar	(16,505)	0	6,704	0	0	0	0	0	0	0	0	(9,801)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,283	0	0	0	0	0	0	0	0	1,283	26
27	Other (specify):*	(15,000)	0	0	0	0	0	0	0	0	0	0	(15,000)	27
28	**TOTAL General Administration**	(44,093)	(178,976)	201,033	0	0	0	0	0	0	0	0	(22,036)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(44,093)	(139,029)	214,753	0	0	0	0	0	0	0	0	31,631	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number Heritage Manor-Minonk **#** 0041392 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	0	0	0	8,529	0	0	0	0	0	0	0	8,529	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(28)	0	0	14,849	0	0	0	0	0	0	0	14,821	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	4,405	0	0	0	0	0	0	0	4,405	34
35	Rent-Equipment & Vehicles	0	0	0	1,105	0	0	0	0	0	0	0	1,105	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(28)	0	0	28,888	0	0	0	0	0	0	0	28,860	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(44,121)	(139,029)	214,753	28,888	0	0	0	0	0	0	0	60,491	45

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
See Attached						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [xx] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V	10a	Adjustment for Related Organization						2
3	V								3
4	V	19	Adjustment for Related Organization	178,976	Heritage Enterprises, Inc.	100.00%		(178,976)	4
5	V								5
6	V	10a	Adjustment for Related Organization	228,189	GreenTree Pharmacy	100.00%	268,136	39,947	6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$ 407,165			$ 268,136	$ * (139,029)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	1	Dietary	$	Heritage Enterprises, Inc.	100.00%	$ 3,178	$ 3,178	15
16	V	2	Food Purchase				0		16
17	V	3	Housekeeping				3	3	17
18	V	4	Laundry				0		18
19	V	5	Heat & Other Utilities				1,003	1,003	19
20	V	6	Maintenance				8,406	8,406	20
21	V	7	Other				0		21
22	V	9	Medical Director				0		22
23	V	10	Nursing & Medical Records				0		23
24	V	11	Activities				0		24
25	V	12	Social Service				0		25
26	V	13	Nurse Aide Training				1,130	1,130	26
27	V	14	Program Transportation				0		27
28	V	15	Other				0		28
29	V	17	Administrative				48,724	48,724	29
30	V	18	Directors Fees				3,617	3,617	30
31	V	19	Professional Services				10,050	10,050	31
32	V	20	Fees, Subscription, Promotions				3,059	3,059	32
33	V	21	Clerical & General Office Expenses				100,572	100,572	33
34	V	22	Employee Benefits & Payroll Taxes				26,176	26,176	34
35	V	23	Inservice Training & Education				848	848	35
36	V	24	Travel and Seminar				6,704	6,704	36
37	V	25	Other Admin. Staff Transportation				0		37
38	V	26	Insurance-Prop.Liab.Malpract				1,283	1,283	38
39	Total			$			$ 214,753	$ * 214,753	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
15	V	27	Other	$	Heritage Enterprises, Inc.	100.00%	$	$ 0	15
16	V	30	Depreciation					8,529	16
17	V	31	Amortization of Pre-Op & Org					0	17
18	V	32	Interest					14,849	18
19	V	33	Real Estate Taxes					0	19
20	V	34	Rent-Facility & Grounds					4,405	20
21	V	35	Rent-Equipment & Vehicles					1,105	21
22	V	36	Other					0	22
23	V	38	Medically Nec Transportation					0	23
24	V	39	Ancillary Service Centers					0	24
25	V	40	Barber and Beauty Shops					0	25
26	V	41	Coffee and Gift Shops					0	26
27	V	42	Other					0	27
28	V								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V								36
37	V								37
38	V								38
39	Total			$			$ 0	$ * 28,888	39

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Susie Jefferson	Director	Management	15.86				Salary/BOD	$ 10,992	Ln 17 & 18	1
2	Estate of Tom Jefferson			16.21				Salary/BOD	0	Ln 17 & 18	2
3	Craig Hart	Chairman	Management	31.95				Salary/BOD	12,330	Ln 17 & 18	3
4	Cheryl Lowney	Executive Vice Presi	Management	0.49		40	100.00	Salary/BOD	7,342	Ln 17 & 18	4
5	Steve Wannemacher	President	Management	0.42		40	100.00	Salary/BOD	9,568	Ln 17 & 18	5
6	Connie Hoselton	Sr Vice President	Management	0.27		40	100.00	Salary	4,721	Ln 17 & 18	6
7	Craig Ater	Sr Vice President	Management	0.34		40	100.00	Salary	5,291	Ln 17 & 18	7
8	Ben Hart	Vice President	Management	3.20							8
9											9
10											10
11											11
12											12
13								TOTAL	$ 50,244		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [xx] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Heritage Enterprises
Street Address: 115 W. Jefferson
City / State / Zip Code: Bloomington,Il
Phone Number: ( )
Fax Number: ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	1	Dietary	Beds	2,612	25	$ 115,289	$ 115,276	72	$ 3,178	1
2	2	Food Purchase	Beds	2,612	25	7	0	72	0	2
3	3	Housekeeping	Beds	2,612	25	124	0	72	3	3
4	4	Laundry	Beds	2,612	25	0	0	72	0	4
5	5	Heat & Other Utilities	Beds	2,612	25	36,387	0	72	1,003	5
6	6	Maintenance	Beds	2,612	25	304,933	79,110	72	8,406	6
7	7	Other	Beds	2,612	25	0	0	72	0	7
8	9	Medical Director	Beds	2,612	25	0	0	72	0	8
9	10	Nursing & Medical Records	Beds	2,612	25	0	0	72	0	9
10	11	Activities	Beds	2,612	25	0	0	72	0	10
11	12	Social Service	Beds	2,612	25	0	0	72	0	11
12	13	Nurse Aide Training	Beds	2,612	25	40,976	40,976	72	1,130	12
13	14	Program Transportation	Beds	2,612	25	0	0	72	0	13
14	15	Other	Beds	2,612	25	0	0	72	0	14
15	17	Administrative	Beds	2,612	25	1,767,611	1,767,611	72	48,724	15
16	18	Directors Fees	Beds	2,612	25	131,223	0	72	3,617	16
17	19	Professional Services	Beds	2,612	25	364,592	0	72	10,050	17
18	20	Fees, Subscription, Promotions	Beds	2,612	25	110,958	0	72	3,059	18
19	21	Clerical & General Office Expens	Beds	2,612	25	3,648,522	3,309,912	72	100,572	19
20	22	Employee Benefits & Payroll Taxe	Beds	2,612	25	949,625	0	72	26,176	20
21	23	Inservice Training & Education	Beds	2,612	25	30,747	0	72	848	21
22	24	Travel and Seminar	Beds	2,612	25	243,204	0	72	6,704	22
23	25	Other Admin. Staff Transportatio	Beds	2,612	25	0	0	72	0	23
24	26	Insurance-Prop.Liab.Malpract	Beds	2,612	25	46,560	0	72	1,283	24
25	TOTALS					$ 7,790,758	$ 5,312,885		$ 214,753	25

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	Beds	2,612	25	$	$	72	$	1
2	30	Depreciation	Beds	2,612	25	309,426		72	8,529	2
3	31	Amortization of Pre-Op & Org	Beds	2,612	25			72		3
4	32	Interest	Beds	2,612	25	538,695		72	14,849	4
5	33	Real Estate Taxes	Beds	2,612	25			72		5
6	34	Rent-Facility & Grounds	Beds	2,612	25	159,809		72	4,405	6
7	35	Rent-Equipment & Vehicles	Beds	2,612	25	40,093		72	1,105	7
8	36	Other	Beds	2,612	25			72		8
9	38	Medically Nec Transportation	Beds	2,612	25			72		9
10	39	Ancillary Service Centers	Beds	2,612	25			72		10
11	40	Barber and Beauty Shops	Beds	2,612	25			72		11
12	41	Coffee and Gift Shops	Beds	2,612	25			72		12
13	42	Other	Beds	2,612	25			72		13
14								72		14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 1,048,023	$		$ 28,888	25

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	LsSalle National Bank		xx	Mortgage	4640 plus Int	01/15/99	$	$ 901,491	01/15/06	variable	$ 50,836	1
2	LsSalle National Bank		xx	Mortgage							4,660	2
3												3
4												4
5												5
	Working Capital											
6	Central Office Allocation		xx	Working Capital							12,070	6
7	Central Office Allocation		xx	Working Capital								7
8												8
9	TOTAL Facility Related						$	$ 901,491			$ 67,566	9
	B. Non-Facility Related*											
10	Interest Income										(28)	10
11												11
12	Central Office Allocation										14,849	12
13												13
14	TOTAL Non-Facility Related						$	$			$ 14,821	14
15	TOTALS (line 9+line14)						$	$ 901,491			$ 82,387	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

* **Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

** **If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Heritage Manor-Minonk **#** 0041392 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2004 report.	$	37,808	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	31,361	2
3. Under or (over) accrual (line 2 minus line 1).	$	(6,447)	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)	$	32,930	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	26,483	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:			
	2000	46,832	8
	2001	29,468	9
	2002	30,873	10
	2003	38,094	11
	2004	35,421	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2004	$		13
14	PLUS APPEAL COST FROM LINE 5	$		14
15	LESS REFUND FROM LINE 6	$		15
16	AMOUNT TO USE FOR RATE CALCULATION	$		16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Heritage Manor-Minonk COUNTY McLean

FACILITY IDPH LICENSE NUMBER 0041392

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	06-07-407-011	Heritage Manor-Minonk	$ 21,339.00	$ 21,339.00
2.	06-07-407-010		$ 10,022.00	$ 10,022.00
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 31,361.00	$ 31,361.00

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 7,560 B. General Construction Type: Exterior brick/wood Frame wood Number of Stories 1

C. Does the Operating Entity? [xx] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [xx] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

none

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [xx] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1				$ 25,000	1
2					2
3	TOTALS			$ 25,000	3

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR BHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	72				$ 1,039,908	$		$	$	$	4
5											5
6											6
7											7
8											8
	Improvement Type**										
9	Smoke Detectors (45)			1998	3,267						9
10	Compressor			1998	1,047						10
11	Generator			1998	12,140						11
12	A/C Repair			1998	1,518						12
13	Plumbing Repair			1998	4,956						13
14											14
15	Water Heater			1996	2,603						15
16	Resident Room Renovating			1996	8,483						16
17	Exterior Painting & Renovation			1996	4,806						17
18	Nurse Call System			1996	3,803						18
19	Garbage Disposal			1996	867						19
20	Boiler Repair			1996	4,436						20
21	Receptionist Work Area Renovation			1996	1,260						21
22	Hot Water Heater			1996	505						22
23	Exterior Signage			1996	1,680						23
24	Interior Rehab			1996	146,288						24
25	Interior Rehab			1996	22,963						25
26	Code Alert System			1996	1,319						26
27											27
28	Interior Rehab			1997	33,578						28
29	Interior Rehab			1997	168						29
30	Building Purchase Offset			1997	(141,199)						30
31											31
32											32
33											33
34	C/O Allocation							8,529	8,529		34
35	Book Depreciation					50,733		50,733		365,285	35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Door Alarm System	1999	$ 10,116	$		$	$	$	37
38	Plumbing / Water Heater	1999	3,170						38
39	Sewage Ejector	1999	3,042						39
40									40
41	Water Heater	2000	3,293						41
42	Remove and replace patio	2000	5,890						42
43									43
44	Garbage Disposal	2001	922						44
45	Painting--Hallways/Resident rooms	2001	2,444						45
46									46
47	Water Faucet	2002	1,656						47
48	Boiler	2002	17,945						48
49	Shower Faucet	2002	2,398						49
50									50
51	Roof	2003	30,757						51
52	Faucets	2003	1,915						52
53	Compressor	2003	1,126						53
54	Disposal	2003	970						54
55									55
56	Water Heater	2004	3,889						56
57	Hot Water Storage Tank	2004	1,744						57
58	Ansul System	2004	1,455						58
59	Door Alarm System	2004	10,914						59
60	Heat Exchanger	2004	1,518						60
61									61
62	Sewage Ejector	2005	3,310						62
63	Circulator Motor	2005	892						63
64	Dry Valve	2005	2,410						64
65	Integrety Bather	2005	827						65
66	Exterior Doors	2005	6,106						66
67	Sprinkler Repair	2005	2,957						67
68	Glass Door	2005	361						68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,276,423	$ 50,733		$ 59,262	$ 8,529	$ 365,285	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,276,423	$ 50,733		$ 59,262	$ 8,529	$ 365,285	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,276,423	$ 50,733		$ 59,262	$ 8,529	$ 365,285	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 178,242	$ 11,595	$ 11,595	$		$ 147,587	71
72	Current Year Purchases	24,698						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 202,940	$ 11,595	$ 11,595	$		$ 147,587	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				$	$	$	$		$	76
77										77
78										78
79										79
80	TOTALS			$	$	$	$		$	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 1,504,363	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 62,328	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 70,857	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 8,529	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 512,872	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
    Beginning
    Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 2,587 Description:
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility.)

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD?
   - ☐ YES
   - ☐ NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - COMMUNITY COLLEGE ☐
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM ☐
   - IN OTHER FACILITY ☐
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		125		125
3	Classroom Wages (a)		2,466		2,466
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$ 2,591	$	$ 2,591
10	SUM OF line 9, col. 1 and 2 (e)	$ 2,591			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities.

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.
(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$ 102,708	$		$ 102,708	1
2	Licensed Speech and Language Development Therapist		hrs			7,839			7,839	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			93,348	767		94,115	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts				268,434		268,434	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					14,415			14,415	13
14	TOTAL			$		$ 218,310	$ 269,201		$ 487,511	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Heritage Manor-Minonk **#** 0041392 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 30,455	$	1
2	Cash-Patient Deposits	5,065		2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	282,586		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	1,067		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	1,980,828		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,300,001	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	25,000		13
14	Buildings, at Historical Cost	1,276,424		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	202,940		16
17	Accumulated Depreciation (book methods)	(512,872)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	388		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 991,880	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 3,291,881	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 33,475	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	5,065		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	126,096		30
31	Accrued Taxes Payable (excluding real estate taxes)	845		31
32	Accrued Real Estate Taxes(Sch.IX-B)	32,930		32
33	Accrued Interest Payable	5,000		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36				36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 203,411	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	901,491		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 901,491	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 1,104,902	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 2,186,979	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 3,291,881	$	48

***(See instructions.)**

Facility Name & ID Number Heritage Manor-Minonk **#** 0041392 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 1,945,449	1	
2	Restatements (describe):		2	
3			3	
4			4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 1,945,449	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	241,530	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	( )	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 241,530	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 2,186,979	24	*

*** This must agree with page 17, line 47.**

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,795,721	1
2	Discounts and Allowances for all Levels	(799,714)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,996,007	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	559,852	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 559,852	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop	2,571	12
13	Barber and Beauty Care	2,121	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	382,217	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	32,507	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 419,416	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	28	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 28	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 2,975,303	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	573,665	31
32	Health Care	1,280,688	32
33	General Administration	721,550	33
	B. Capital Expense		
34	Ownership	157,859	34
	C. Ancillary Expense		
35	Special Cost Centers	11	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 2,733,773	40
41	**Income before Income Taxes (line 30 minus line 40)****	241,530	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 241,530	43

*** This must agree with page 4, line 45, column 4.**

**** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

***** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)

(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,616	1,788	$ 40,923	$ 22.89	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	4,330	4,763	102,892	21.60	3
4	Licensed Practical Nurses	8,471	9,330	157,663	16.90	4
5	CNAs & Orderlies	37,624	40,241	406,305	10.10	5
6	CNA Trainees	300	300	2,466	8.22	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	1,648	1,739	14,623	8.41	8
9	Activity Director					9
10	Activity Assistants	3,763	3,923	34,559	8.81	10
11	Social Service Workers	1,048	1,328	18,823	14.17	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
15	Cook Helpers/Assistants	16,305	17,884	148,650	8.31	15
16	Dishwashers					16
17	Maintenance Workers	4,125	4,631	40,183	8.68	17
18	Housekeepers	7,658	8,281	69,406	8.38	18
19	Laundry	5,775	5,961	55,132	9.25	19
20	Administrator	1,900	2,080	62,320	29.96	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	4,062	4,772	66,994	14.04	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	98,625	107,021	$ 1,220,939 *	$ 11.41	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant		$ 0		35
36	Medical Director		750		36
37	Medical Records Consultant		1,575		37
38	Nurse Consultant				38
39	Pharmacist Consultant		2,160		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		2,228		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		$ 6,713		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	0	$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Kim Seaman	admin		$ 62,320
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 62,320

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Heritage Enterprises	Mgt Fees	$ 178,976
		0
		0
		0
		1,520
		0
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 180,496

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 49,299
Unemployment Compensation Insurance	21,936
FICA Taxes	93,402
Employee Health Insurance	81,801
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Hepatitis Vaccine	0
Employee Benefits -	20,896
Employee Benefits - central office	26,176
TOTAL (agree to Schedule V, line 22, col.8)	$ 293,510

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	4,521
Health Care Worker Background Check	
(Indicate # of checks performed)	320
Central Office Allocation	3,059
Promotional Advertising	3,169
Public Relations	7,553
Dues and Subscriptions	5,226
License and Fees	230
Less: Public Relations Expense	(7,553)
Non-allowable advertising	(346)
Yellow page advertising	(3,169)
TOTAL (agree to Sch. V, line 20, col. 8)	$ 15,000

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
	6,820
	53
Seminar Expense	4,927
	(16,505)
	6,704
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,999

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Heritage Manor-Minonk # 0041392 Report Period Beginning: 01/01/05 Ending: 12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Heritage Manor-Minonk **#** 0041392 **Report Period Beginning:** 01/01/05 **Ending:** 12/31/05

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **no**

(2) Are there any dues to nursing home associations included on the cost report? **yes**
If YES, give association name and amount. **Illinois Healthcare Association**

(3) Did the nursing home make political contributions or payments to a political action organization? **yes** If YES, have these costs been properly adjusted out of the cost report? **yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **no** If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? **yes**
What was the average life used for new equipment added during this period? **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **5,000** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **no**
If YES, give effective date of lease.

(9) Are you presently operating under a sublease agreement? YES **xx** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **xx** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. $ **26,828**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **no** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **yes** Indicate the amount. $ **4,474**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **no**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **no** If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? **100%**
d. Have vehicle usage logs been maintained? **yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **yes**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **yes**
g. Does the facility transport residents to and from day training? no
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? **yes**
Firm Name: **Sulaski & Webb** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **No** If no, please explain. **Not available**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **yes**
Attach invoices and a summary of services for all architect and appraisal fees.

BASIC CHARGE-PRIVATE & VA	-2,617,039	
PRIVATE ASSESSMENT TAX INCOME		
BASIC CHARGE-IPA	0	
BASIC CHARGE-MEDICARE	0	
DAY CARE/HOME CARE		
LIGHT NURSING CARE	-53,280	
MEDIUM NURSING CARE		
HEAVY NURSING CARE		
NURSING SUPPLIES-PRIVATE	-112,099	
NURSING SUPPLIES-IPA		
NURSING SUPPLIES MED PT A		
NURSING SUPPLIES MED PT B		
DRUGS	-382,217	
DRUGS-OTHER		
PT-PRIVATE	-559,852	
PT-IPA		
PT-MEDICARE PART A		
PT-MEDICARE PART B		
PT-MEDICARE ASSESSMENT INC		
LABORATORY INCOME		
SPEECH/OT-PRIVATE		
SPEECH/OT-IPA		
SPEECH/OT-MED PART A		
SPEECH/OT MED PART B		
IPA DISCOUNTS	799,714	
MEDICAID PART B DISCOUNT		
MEDICARE DISCOUNTS		
ASSESSMENT TAX EXPENSE		
RENT INCOME	0	
BEAUTY SHOP	-2,121	
ACTIVITY FUND INCOME	0	
ASSESSMENT TAX EXPENSE	-2,571	
MANAGEMENT FEES		
EQUIPMENT RENTAL	-14,503	
RESIDENT TRANSPORTATION	-19,500	
MISC INCOME	-12,998	
GENERAL & ADMINIST WAGES	65,313	66,994
ADMINISTRATOR WAGES	62,320	62,320
VACATION & SICK - G&A	1,681	
EMPLOYEE BENEFITS	5,982	247,334
EMPLOYEE HEPETITIS VACCINE	0	
EMPLOYEE SCHOLORSHIP WAC	12,600	
EMPLOYEE SCHOLORSHIP COST	2,314	
DIRECTORS FEES		
OFFICE SUPPLIES	5,650	5,650
TELEPHONE	15,566	15,566
TRAINING & EMPLOYEE DEVL	1,134	1,134
GENERAL TRAVEL	6,820	11,880
MEAL EXPENSE FOR TRAVEL	53	
EDUCATION & SEMINAR	4,927	
HELP WANTED ADVERTISING	4,521	49,837
PROMOTIONAL ADVERTISING	3,168	
PUBLIC RELATIONS	7,553	
LICENSES & FEES	29,048	
DUES & SUBSCRIPTIONS	5,226	
CONTRIBUTIONS	0	
PROFESSIONAL FEES	1,520	180,496
AUDIT & LEGAL FEES	750	750
UTILIZATION REVIEW	0	
OTHER PHYSICIAN FEES	0	
MEDICAL RECORDS CONSULT	1,575	
PHARMACIST FEES	2,160	
SOC SERV/ACT CONSULT	2,220	2,220
TV RENTAL	0	
INCOME TAXES		15,885
BACKGROUND CHECKS	320	
PAYROLL TAXES	109,728	
PAYROLL TAXES ADMINIST	1,610	
PAYROLL TAXES	81,654	
LIABILITY INSURANCE	64,534	64,534
INSURANCE-OWNERS		
WORKMENS COMP INSURANCE	49,209	
CENTRAL OFFICE FEES	178,976	
BAD DEBTS	15,000	
LOST ITEMS-RESIDENTS	885	
MISCELLANEOUS	0	
REAL ESTATE TAXES	26,483	26,483
LEASED EQUIPMENT	1,482	1,482
MAINTENANCE SALARIES	37,018	40,183
MAINTENANCE SICK & VAC	3,165	
ELECTRIC	37,498	93,635
NATURAL GAS	36,851	
HEATING & DIESEL OIL		
WATER & SEWER	20,086	
TRASH COLLECTION	3,368	17,004
PROPERTY PLANT REPLACEMN	7,144	23,193
GENERAL REPAIR & MAINT	16,049	
MAINTENANCE CONTRACTS	13,636	
DIETARY WAGES	135,781	148,650
DIETARY SICK & VAC	12,867	
SALES TAX		
FOOD PURCHASES	96,441	91,967
SUPPLIES-DISHWASHING	1,482	14,386
DIETARY REPLACEMENT	1,270	
DIETARY SUPPLIES-PAPER	4,179	
MEAL CREDIT	-6,474	
LAUNDRY WAGES	51,577	55,132
LAUNDRY SICK & VAC	3,555	
LAUNDRY REPLACEMENT	3,961	8,745
LAUNDRY REIMBURSEMENT		
LAUNDRY SUPPLIES	4,784	
HOUSEKEEPING WAGES	61,841	69,486
HOUSEKEEPING SICK & VAC	7,565	
HOUSEKEEPING SUPPLIES	3,432	11,364
HOUSEKEEPING SUPPLIES-PPR	7,932	
RN WAGES-MEDICARE		722,406
RN WAGES-NON MEDICARE	94,707	
RN WAGES	40,539	
ADON	0	
RN SICK & VACATION	8,095	
LPN WAGES-MEDICARE	0	
LPN WAGES-NON MEDICARE	147,891	
LPN WAGES OTHER		
LPN SICK & VACATION	9,772	
AIDE WAGES-MEDICARE		
AIDE WAGES-NON MEDICARE	369,311	
WARD CLERKS		
AIDE VACATION & SICK	36,994	
CONTRACT NURSES-RN	0	
CONTRACT NURSES-LPN	0	
CONTRACT NURSES-AIDES	0	
NURSE AIDE TRAINING WAGES	2,466	2,466
NURSE AID TRAINING EXP	125	125
NURSE AIDE TRAINING REIMB	0	
REHAB WAGES	14,566	
REHAB SICK & VAC	57	
NURSING DEPT EDUCATION		
NURSING SUPPLIES	39,894	45,691
NURSING SUPPLIES	5,246	
REPLACEMENT-NURSING	551	
NURSING-OTHER	54	3,789
DRUG PURCHASES	114,686	229,254
DRUG PURCHASES-OTHER	111,586	
LABORATORY SERVICES	14,415	218,310
HOME HEALTH SALARY		
HOME HEALTH SICK & VAC		
HOME HEALTH EXPENSES		
ACTIVITES WAGES	33,254	34,559
ACTIVITIES SICK & VAC	1,305	
ACTIVITIES SUPPLIES	2,287	2,287
ACTIVITIES FEES	0	0
PT WAGES		
PT SICK & VACATION		
PT FEES	932,348	
PT SUPPLIES	767	
SOCIAL SERVICE WAGES	16,412	18,023
SOCIAL SERVICE SICK & VAC	2,411	
SOCIAL SERVICE EXPENSES	0	0
OT FEE	102,708	
SOCIAL THERAPIST FEE	0	0
SPEECH THERAPY FEE	7,039	
BEAUTICIAN WAGES		0
BEAUTICIAN SICK & VAC		
BEAUTICIAN FEES	0	0
BEAUTY SHOP SUPPLIES	11	11
VOLUNTEER COORDINATOR		
VOL COORD SICK & VAC		
VOL COORD SUPPLIES	0	
RENT		0
INTEREST EXPENSE	62,986	67,566
DEPRECIATION	62,320	62,320
LOAN FEE AMORTIZATION	4,660	
INTEREST INCOME	-24	
MISC NON-OPERATING INCOME	0	
INCOME TAXES	0	
	2,733,745	2,733,773
		28
	-240,530	
	(NET INCOME)	
	0	

						2,612	72	3,471,750	71,391,262	
	Name	Title	Function	Total Pay	ısted by Mgmt F	otal # Bed:	acility # Be	on-Nursing Hor	Nursing Home	This Facility
###	Susie Jefferson	Director	Manageme	418,245	418,245			19,396	398,849	10,992
###	Tom Jefferson	Secretary	Manageme	0	0			0	0	0
###	Craig Hart	Chairman	Manageme	469,049	469,049			21,752	447,297	12,330
###	Cheryl Lowney	Executive Vice Presic	Manageme	279,290	279,290			12,952	266,338	7,342
###	Steve Wannemache	President	Manageme	363,969	363,969			16,879	347,090	9,568
###	Connie Hoselton	Sr Vice President	Manageme	179,584	179,584			8,328	171,256	4,721
###	Craig Ater	Sr Vice President	Manageme	201,279	201,279			9,334	191,945	5,291
	Ben Hart			79,758	79,758			3,699	76,059	2,097
13				1,991,174	1,991,174				1,898,834	52,341